TENNESSEE DEPARTMENT OF HEALTH
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM
FOR WOMEN, INFANTS, AND CHILDREN

2012 – 2014 VENDOR APPLICATION FOR AUTHORIZATION TO PARTICIPATE IN THE TENNESSEE WIC PROGRAM	**FOR WIC USE ONLY** **REG. _____ CO._____ VENDOR NO. _____** **Sanitation Score _____** **Peer Group _____** **Vendor Rep _____** **Date Rec'd _____ Date Approved _____**

Follow instructions and review prior to submitting to WIC Regional Office. Complete in ink or type.

Only completed applications, including required attachments, will be processed.

Pharmacy applicants (Independent or Chain Pharmacies not associated with a grocery store.)

must complete all items except where noted Not Applicable (N.A.).

PART I. STORE IDENTIFICATION

1. STORE NAME _____

2. TENNESSEE SALES TAX NUMBER _____

3. SQUARE FOOTAGE OF STORE _____

4. STORE ADDRESS

A. PHYSICAL LOCATION - DO NOT SHOW POST OFFICE BOX NUMBER.

Street Address/Rural Route Number _____

City _____

County _____ State _____ Zip _____

Store Telephone Number: Area Code _____ Number _____ Fax: AC _____ No. _____

E-mail address _____

B. MAILING ADDRESS - DO NOT COMPLETE IF MAIL CAN BE DELIVERED TO THE STORE'S PHYSICAL LOCATION. POST OFFICE BOX MAY BE SHOWN HERE.

Office/ Apartment Number _____Street Number _____ Street Name/ P.O. Box _____

City _____ State _____ Zip _____

5. WHEN DID (OR WILL) THE STORE OPEN FOR BUSINESS UNDER CURRENT OWNERSHIP?

Month _____ Day _____ Year _____

6. TYPE OF BUSINESS - Check one type

- ☐ Major Chain - Multiple States
- ☐ Independent Chain - Local Corporate Ownership
- ☐ Franchise - Multiple Locations
- ☐ Franchise - Single Location
- ☐ Independent - Not a Franchise
- ☐ Pharmacy
- ☐ Commissary

- **How many stores are under the same ownership? _____ (Include applying store.)**
- **How many of these stores are currently authorized for the TN WIC Program or any other WIC Program? _____ (Include applying store if currently authorized.)**

PART II. STORE OWNERSHIP AND MANAGEMENT

7. TYPE OF OWNERSHIP - Check one type:

☐ Sole Proprietorship ☐ Partnership ☐ Privately-held corporation ☐ LLC

☐ Publicly-owned corporation ☐ Cooperative ☐ Government-owned

8. OWNERSHIP IDENTIFICATION

A. NAME AND ADDRESS OF THE BUSINESS IF DIFFERENT FROM PART 1 - (Parent corporation, if store is company owned)

Business Name _____

Street Number _____ Street Name/P.O. Box _____

City _____ State _____ Zip _____

B. OWNER'S NAME AND HOME ADDRESSES - Do not enter this information for publicly-owned corporations. Enter requested information below for owners of sole proprietorships, partnerships, principal shareholders of private corporations, LLC members, or officers of a cooperative. Include spouses in community property states. If more than two owners, attach to this application the same information for up to three more persons. **PRESENT NAME EXACTLY AS SHOWN ON LEGAL DOCUMENTS.**

1. First Name _____ Last Name _____ Title _____

Street Number _____ Street Name/P.O. Box _____

City _____ State _____ Zip Code _____ Home Phone _____

2. First Name _____ Last Name _____ Title _____

Street Number _____ Street Name/P.O. Box _____

City _____ State _____ Zip Code _____ Home Phone _____

9. STORE MANAGER IDENTIFICATION

Name the person with primary on-site responsibility for daily operations:

First Name _____ Last Name _____

Chain Store District Manager's Name: First Name_____ Last Name_____

E-Mail Address_____ Fax Number with area code _____

Street Name/P.O. Box _____

City _____ State _____ Zip Code _____ Phone _____

10. OWNERSHIP HISTORY OF VENDOR APPLICANT

A. Do any of the current owners now own or operate, or have they previously owned or operated, a firm or firms for which an application to participate in any WIC Program was submitted? ☐ YES ☐ NO. IF YES, attach a list of stores, except for chain stores. Identify the store's full name and approximate date of application or last authorization if known.

B. Including this store, has any current owner, officer or manager(s) ever owned or managed a firm which violated any WIC Program's regulations and was disqualified or fined? ☐ YES ☐ NO. IF YES, attach an explanation identifying the person or corporation and the store name and location related to the violation and the year of the violations if known.

C. Has any current owner, officer or manager(s) ever had a license denied, withdrawn or suspended, or fined for license violations (e.g., business or health licenses)? ☐ YES ☐ NO. IF YES, attach an explanation, listing the type of license, the reason for denial, fine or suspension, withdrawal or disqualification.

D. During the past six years, has any current owner, officer, or manager(s) been convicted of, or had a civil judgment, for any of the following activities: fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice? ☐ YES ☐ NO. IF YES, attach a written explanation specifying the name of the owner, officer, or manager, the activities involved, and date of judgement and court name.

PART III. STORE OPERATIONS AND SALES

11. WHAT HOURS IS THE STORE OPEN? _____ (Example: M - F 7am to 11pm,

_____ Sat - Sun 7 am to 12 am)

12. HOW MANY CASHIERS WORK IN THIS STORE? (Include paid and unpaid, full and part-time, owners and family) Number _____

13. HOW MANY CASH REGISTERS DO YOU HAVE? Number _____

Do these registers have optical scanners? ☐ YES ☐ NO. IF YES, can they scan specifically for WIC? ☐ YES ☐ NO

14. IS THIS STORE AUTHORIZED FOR THE SUPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) (FORMERLY THE FOOD STAMP PROGRAM)?

☐ YES ☐ NO ☐ APPLIED FOR ☐ PHARMACY NOT SNAP AUTHORIZED

NOTE: GROCERY APPLICANTS MUST BE SNAP AUTHORIZED FOR THIS APPLICATION TO BE ACCEPTED. PHARMACIES WITH CURRENT SNAP AUTHORIZATION OR WHO WERE PREVIOUSLY DISQUALIFIED OR ISSUED A CIVIL MONEY PENALTY BY SNAP MUST CHECK "YES" AND COMPLETE THIS SECTION.)

A. If yes, what is your SNAP Authorization Number? _____ (Not your WIC Vendor Number)

If you are NOT currently participating in the Tennessee WIC Program, attach a copy of the SNAP Authorization.

B. Has this store ever been denied or disqualified from SNAP? ☐ YES ☐ NO. IF YES, attach a written explanation, giving the date denied or disqualified, and the reasons.

C. Has this store ever been placed on probation or received a Civil Money Penalty from SNAP?

☐ YES ☐ NO. IF YES, attach a written explanation including the probation period or amount of Civil Money Penalty.

15. BANK WHERE YOU WILL DEPOSIT WIC FOOD INSTRUMENTS AND CASH VALUE VOUCHERS.

The information below should be for regular banking activities.

NOTE: THIS INFORMATION MAY BE DIFFERENT FROM THAT PROVIDED FOR ACH PAYMENTS. ALL VENDORS MUST BE ENROLLED TO RECEIVE AUTOMATED CLEARING HOUSE (ACH) PAYMENTS.

Bank _____ Branch Name _____

Number _____ Street _____

City _____ State _____ Zip _____

Telephone Number: Area Code _____ Number _____

16. MAJOR WHOLESALER, DISTRIBUTOR, RETAILER, OR MANUFACTURER FROM WHOM WIC FOODS ARE PURCHASED.

Name _____

Number _____ Street _____

City _____ State _____ Zip _____

Telephone Number: Area Code _____ Number _____

● IS INFANT FORMULA PURCHASED FROM SAME WHOLESALER, DISTRIBUTOR, RETAILER, OR MANUFACTURER?

☐ YES ☐ NO. If NO, please provide above information on a separate sheet of paper and attach to application.

17. GROSS (TOTAL) SALES FIGURES:

A. CHECK APPROPRIATE BOX – PLEASE GIVE YEARLY (NOT MONTHLY) AMOUNT: If giving estimated sales, you must provide a dollar amount for one year that is equal to one month times 12. However, report estimated sales only if you do not have actual sales figures for the most recent tax year. You may be required to provide updated information when actual sales figures are available.

☐ Actual Gross Sales $ _____ For tax year _____

☐ Estimated Gross Sales $_____ For tax year _____

B. **(N.A. FOR PHARMACIES)** STAPLE FOODS CATEGORIES CARRIED IN STOCK: (Staple foods do not include any prepared foods or accessory foods such as candy, condiments, spices, tea, coffee, or carbonated and un-carbonated drinks.) Staple foods include, but are not limited to the following:

- ☐ Infant formula, juice and cereal
- ☐ Eggs
- ☐ Dairy products
- ☐ Breads and baked goods
- ☐ Rice, pasta, cereal, chips, cookies, crackers, etc.
- ☐ Fresh fruits and vegetables
- ☐ Frozen and canned fruits and vegetables
- ☐ Fish/Seafood
- ☐ Meat (beef, pork, lamb, etc.)
- ☐ Poultry/Fowl (chicken, turkey, etc.)

C. **(N.A. FOR PHARMACIES)** Percent of sales (17A) represented by the sale of staple foods:

☐ Less than 25% ☐ 26-50% ☐ 51-75% ☐ More than 75%

18. TOTAL FOOD SALES AS BASED ON FACT SHEET (ATTACHMENT 1) INCLUDED WITH APPLICATION (MUST BE COMPLETED BY ALL APPLICANTS.)

A. CHECK APPROPRIATE BOX BELOW TO REPORT YEARLY TOTAL FOOD SALES: If giving estimated sales, you must provide a dollar amount for one year that is equal to one month times 12. However, report estimated sales only if you do not have actual sales figures for the most recent tax year. You may be required to provide updated information when actual sales figures are available.

☐ Actual Food Sales $ _____ For tax year _____

☐ Estimated Food Sales $ _____ For tax year _____

PLEASE NOTE: To assist in completing 18 B., WIC Food Instruments (FIs) provide eligible WIC food other than fresh and frozen fruits and vegetables. Cash Value Vouchers (CVVs) provide eligible fresh and frozen fruits and vegetables.

B. PAYMENT TYPES BY PERCENT: Do you expect that more than 50 percent of this location's annual revenue from the sale of food items will come from WIC FIs alone ☐ YES ☐ NO **or (N.A. TO PHARMACIES)** both WIC FIs and CVVs ☐ YES ☐ NO?
If both answers are "NO", **(just the first "NO" for pharmacies),** what is the estimated percent of annual **total food sales** for the following types of payment?
Cash/Personal Checks _____% SNAP _____% WIC _____% Debit/Credit Cards _____%

(N.A. FOR PHARMACIES) What is the estimated percent of **annual WIC food sales** for: FIs _____% CVVs _____%

PLEASE NOTE: IN ADDITION TO INFORMATION PROVIDED ON THIS APPLICATION, YOU MAY BE ASKED TO SUBMIT RECORDS REGARDING SALES, INVOICES AND/OR INVENTORY AS WELL AS COPIES OF INCOME AND SALES TAX RELATED FORMS. FAILURE TO MEET SUCH REQUESTS SHALL RESULT IN DENIAL OF YOUR APPLICATION. (As allowed by the federally issued Vendor Cost Containment Final Rule, the Tennessee WIC Program has chosen to prohibit authorization of new vendor locations expected to have more than fifty (50) percent of its annual food sales purchased with WIC FIs. In addition, the Tennessee WIC Program requires authorized groceries to carry a full market basket of foods. This is to provide opportunity for price comparison shopping and for nutrition information comparison. However, the Tennessee WIC Program has the sole responsibility to determine if approval of this application is necessary to assure participant access to WIC Program benefits.)

PART IV. STATEMENTS AND CERTIFICATION

COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE AUTHORIZATION TO PARTICIPATE IN THE WIC PROGRAM.

PRIVACY ACT STATEMENT - The collection of this information is authorized by Part 246.12 of Federal Regulations 7CFR, Ch.11 which governs the Special Supplemental Nutrition Program for Women, Infants, and Children. It will be used to determine whether a store qualifies to participate in the WIC Program; to monitor compliance with program regulations; and for program management. The provision of the requested information, including the Tennessee Sales Tax Number is voluntary. However, failure to provide information may result in the denial or withdrawal of authorization to participate in the WIC Program. The purpose of collection of this information is for audit and enforcement of WIC Program regulations.

WARNING STATEMENT - Information in this application may be verified with other agencies. WIC Program participation shall be denied or withdrawn if any application information is false; in addition, you may be fined up to $25,000 or imprisoned for up to five years or both for concealing any material fact, making false statements or representation, or using any false writing or documentation in connection with the application. Authorization may be denied or terminated if the firm violates any laws or regulations issued by Federal, State, or local programs including SNAP for violating SNAP regulations.

CERTIFICATION AND SIGNATURE OF OWNER (or person who has the ability to apply on behalf of the store.)

1. **I apply for authorization for this store to take part in the WIC Program, and I have authority to enter into a WIC Vendor Agreement between this firm and the Tennessee Department of Health.**
2. **I understand that prices for WIC approved foods shall be competitive with and not exceed the average shelf price of other vendors in the same peer group and area by more than the stated percentage at the time of authorization as a WIC Vendor and throughout the period for which the WIC Vendor Agreement shall be in effect. (N.A. FOR PHARMACIES)**
3. **I understand that my stock of WIC approved foods must meet the WIC Program requirements for minimum variety and quantity at the time of authorization as a WIC Vendor and throughout the period for which the WIC Vendor Agreement shall be in effect. (N.A. FOR PHARMACIES)**
4. **I understand that my authorization as a WIC vendor is subject to the WIC Program's verification of a positive compliance history with sanitation authorities. (N.A. FOR PHARMACIES)**
5. **I did read and do understand the penalties in the warning statement above. I understand that false or incomplete information provided to the WIC Program or violation of the terms of the WIC Vendor Agreement shall result in the termination of that agreement.**
6. **I understand that the ownership and management of this store will be responsible for understanding the requirements, policies, and procedures appearing in the WIC Vendor Handbook which is considered part of the WIC Vendor Agreement. This information shall be presented during both initial and follow-up training for this store's authorization as a WIC vendor. I further understand that I or another representative of the store will have an opportunity to ask questions during the training sessions.**

SIGNATURE _____ DATE _____

PRINT NAME _____ TITLE _____

DAYTIME PHONE NUMBER _____

In accordance with Federal law and Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director of Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.